School Entry Dental Examination

Health and Wellness Services
1200 South Barr Street ● Fort Wayne, IN 46802 ● Phone: 260.467.1080 ● Fax: 260.467.2862

Student's name _____ Birth Date ____/____/____
(Last) (First) (M.I.)

Street address _____

City/Zip _____

School _____

Dentist's name _____

THE FOLLOWING TO BE COMPLETED BY EXAMINING DENTIST

1. Untreated decay in deciduous teeth ☐ YES ☐ NO
2. Untreated decay in permanent teeth ☐ YES ☐ NO

   If yes, to 1 or 2, please answer a, b, and c below.

   a. Decay is classified as early childhood caries/baby bottle caries (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected) ☐ YES ☐ NO
   b. Decay is classified as rampant caries in permanent teeth ☐ YES ☐ NO
   c. Child is experiencing pain *and/or* infection ☐ YES ☐ NO
3. Occlusion is within normal range for age ☐ YES ☐ NO

   If no, immediate follow-up is indicated ☐ YES ☐ NO
4. Oral hygiene ☐ Optimal ☐ Needs Improvement
5. This is child's first dental treatment completed ☐ YES ☐ NO
6. All necessary dental treatment completed ☐ YES ☐ NO

   If no, appointments are made for completing treatment ☐ YES ☐ NO

COMMENTS:

Dentist's signature _____ Date _____